The National Planning Commission:

Draft National Development Plan

Chapter 10 on Health

Draft, 11 November 2011

Extracts

Introduction

There are three major perspectives to be considered in assessing the South African national health system and offering recommendations to promote health and prevent and manage problems.

- Demographics and health – trends in demography, vital statistics and the burden of disease-specific morbidity and mortality.

- Health systems – issues such as health finance, workforce, infrastructure, information, technology and governance. This provides insight into the capacity of the health system to respond to challenges presented in the first perspective.

- The environmental/social determinant perspective, which involves the social and ecological determinants of health, including climate change and global trends.

Underpinning the national health system philosophy are two interlinked ideas: the equalising principles of primary health care and the decentralised, area-based, people-centred approach of the district health system. Primary health care emphasises globally endorsed but widely neglected values, such as universal access, equity, participation and an integrated approach. It emphasises the importance of prevention and using appropriate technology.

Primary health care principles continue to be important considerations for health policy-makers. South Africa has a long history of commitment to primary health care. The first attempts to establish a community-oriented primary care approach, based on a network of decentralised health centres, dates back to the 1940s. Although these efforts were never fully realised because of apartheid policies, the importance was recognised in the African National Congress (ANC) National Health Plan of 1994. The key components of primary care include enhanced access to and use of first-contact care, a patient-focused (rather than disease-focused) approach, a long-term perspective, comprehensive and timely services, and home-based care when necessary.

From Page 3

Vision for health 2030

We envisage that in 2030, South Africa has a life expectancy rate of at least 70 years for men and women. The generation of under-20s is largely free of HIV. The quadruple burden of disease [*four disorders that contribute mostly to morbidity and mortality in South Africa namely, HIV/AIDS, Tuberculosis and sexually transmitted diseases maternal and child mortality, non-communicable diseases, and violence, injuries and trauma*] has been radically reduced compared to the two previous decades, with an infant mortality rate of less than 20 deaths per thousand live births and an under-five mortality rate of less than 30 per thousand. There has been a significant shift in equity, efficiency, effectiveness and quality of health care provision. Universal coverage is available. The risks posed by the social determinants of disease and adverse ecological factors have been reduced significantly.

From Pages 13 and 14

Financing the health system

In 2005, the World Health Assembly passed a resolution on sustainable health financing, universal coverage and social health insurance. The resolution noted a wide mix of financing mechanisms across countries, but asked countries to commit to progressively extending a pre-payments system. This measure was aimed at increasing security of services, protecting against financial risk, preventing catastrophic health expenditure and moving towards universal systems.

Health system typologies

Occasionally, policy-makers and countries relook at the long-term direction and nature of their health systems and chart a fundamentally different approach for the road ahead. South Africa is at such a juncture, where the proposals for a national health insurance (NHI) system represent a profound break with the past and the potential evolution of a substantially different system. Changes we make now may set the foundations for a new health system for the next 50 years.

South Africa has a transitional or pluralist health system, consisting of a tax-funded health system for the majority and a system of medical schemes for a relatively small proportion of the population (17 percent, 8.3 million beneficiaries). [*Council for Medical Schemes, Annual Report 2010/11*] However, given the large inequities in income, spending within the private system amounts to about half of total health spending. This high level of spending in the private sector attracts scarce skills away from the public sector: a large proportion of South Africa's specialists, pharmacists, dentists, optometrists and physiotherapists work in the private sector. South Africa's level of public health spending (4.1 percent of GDP) is fairly average in global terms, but its high level of HIV/AIDS and burden of disease [*Mortality and burden of disease estimates for WHO member states 2004*. *WHO, Geneva, 2009*] gives the country an additional cost burden that has been estimated at around 0.7 percent of GDP [*Guthrie T, Ndlovu N, Muhib F and Hecht R (2010). The long run costs and financing of HIV/AIDS in South Africa. Cape Town: Centre for Economic Governance and AIDS in Africa Cape Town; Haaker M (2011). Fiscal implications of HIV/AIDS in South Africa. Washington: World Bank.*]

It is unusual for middle-income countries to spend more than 6 percent of GDP on health, while countries with higher income, such as the United Kingdom, spend about 8 percent of GDP on health services. As countries become more developed and richer, their health systems and financing systems typically move away from these transitional systems towards more universal systems, in which a large proportion of health funding is public. In advanced countries, there are three main types of health system:

- National health service: United Kingdom, Spain and Sweden. Services are predominantly tax funded and delivery is mainly through the public sector.

- National health insurance: Financing is predominantly public, but delivery is typically by a mix of public and private providers. There is a range of sub-options here, but one of the main differences lies between the single-payer models (Australia and Canada) and the multi-payer models, which typically

emerge and build on occupational social health insurance scheme arrangements (Holland and Germany).

- Private health insurance: The United States model of private health insurance is generally considered one of the most expensive and inefficient, and is being reviewed under the Obama health reforms.

When social insurance systems reach universal coverage, the distinctions between health insurance and health service systems may become blurred. In South Africa, the term NHI may be open to misinterpretation, as it will not be a typical insurance system. It will be predominantly based on public provision at first, and mainly funded through general tax revenues.

Evolution towards NHI

NHI is a common end-point for health financing reforms across the world and over 100 countries either have or are moving towards such systems. In many countries, NHI has evolved over decades through the progressive elaboration of social health insurance. As economies strengthen and a growing proportion are employed in the formal sector, a relatively low percentage of remaining uninsured people are subsidised to bring the entire population into the insurance system. South Africa is working towards this objective of achieving universal coverage. This approach has to be tailored to the South African context:

- Progressive inclusion of private providers into the publicly funded system is likely to be much more gradual given their substantially higher unit costs. The Green Paper already talks of a transition of 14 to 15 years. In the early years, the system will have to focus substantially on strengthening the public health service, similar to a national health service-type system.

- The system will involve substantial cross-subsidisation in the early decades, due to high levels of unemployment and income inequality.

South African health financing numbers

South Africa will spend about 8.7 percent of GDP on health services in 2011/12 (R255 billion), of which about 4.2 percent (R122 billion) will be in the public sector, 4.3 percent through private financing streams (R126 billion) and 0.2 percent through donors. The largest public stream is through provincial departments of health (3.8 percent of GDP) and the largest private stream is through medical schemes (3.6 percent of GDP).

Pages 16-26 (without tables)

Government spends about R922 per month on health services per family of four, which is roughly 14.7 percent of the main budget (excluding interest costs). A similar family covered by a medical scheme spends between four and five times as much per month. South Africa has not quite met the Abuja declaration health spending target of 15 percent of government spending.

Health financing system components

Although the broad description of a national health system is important, of more significance are the detail and design of the financing system through which varied options emerge. The costs of NHI depend on the type of system, for example, the nature and type of benefits, the extent to which private providers (private hospitals) are used, the nature of reimbursement mechanisms, how much purchasing is active or passive, the degree of genuine competition, the relative power of purchasers and providers, usage levels of services and how successfully demand is managed.

Revenue collection

Sources of funds: households, firms, government, donors (tax base)
Mechanisms of health care financing/contribution mechanisms: (type of revenue stream)

- Tax – direct/indirect, personal income tax, value added tax, borrowing
- Social insurance, NHI
- Private insurance, medical schemes
- User fees – out of pocket
- Community financing
- Donations/grants.

Types of collecting agency: Government, parastatal, private

Pooling

Risk pools

- Coverage and composition of risk pools and degree of fragmentation
- Number and nature of purchasing authorities.

Resource allocation

- Degree to which need based (risk equalised)
- Needs-based resource allocation formulae (e.g. risk-adjusted capitation).

Purchasing

- Transfer of pooled funds to providers
- Active vs passive purchasing; contracting; information systems
- Benefit package
- Budgeting, allocative efficiency
- Payment mechanisms.

The rough cost estimates provided in the Green Paper on the NHI are briefly portrayed in the table below. Public health spending will increase from R100-R110 billion at baseline to R255 billion in real terms by 2025 (R574 billion in nominal terms). As a percentage of GDP, this is an increase from about 4.2 percent to 6.2 percent.

However, the actual costs will vary depending on the way in which the NHI is implemented, and wider health system issues, such as increasing the supply of doctors.

The financing of a health care system does not depend solely on its cost projections. It is subject to many other factors, such as relative prioritisation of different sectors (health services versus education, income support, infrastructure, job creation), the overall fiscal stance of the country, its economy, the ability of the sector to convincingly show value for money and political choices.

Examining international comparisons suggests that certain countries provide inadequate levels of funding for health services. For example, in India, until fairly recently, the level of public sector health funding was close to 1 percent of GDP, despite very high levels of maternal and child mortality. At the other end of the spectrum, poorly conceived health systems can bankrupt companies and governments. The United States health care system costs close to 14 percent of GDP, yet many people are uncovered and the country has comparatively poor health outcomes. In Germany, mandatory contributions cost 15 percent of payroll and have, at times, been considered unaffordable for the country and the economy. Cost spirals in health systems are easily set off and can be very difficult to control. It is important to design health systems with long-term sustainability.

Cost controls

Many mechanisms need to be put in place within health systems to improve efficiency and control costs. For example, primary care gate-keeping; demand management strategies such as appropriate self care, user fees; rationing, diagnostic and therapeutic protocols, preferred providers; managed care; reimbursement strategies (capitation or global budgets instead of fee-for-service) and others. The *World Health Report* estimated that between 20 percent and 40 percent of health spending globally is wasted through inefficiency and made diverse recommendations for greater efficiency.

Financing mechanisms

Distinct financing mechanisms could be used to generate funds for the health system and for NHI. Some common financing mechanisms for health care internationally include:

- Tax – direct/indirect, personal income tax, value added tax, borrowing
- Social insurance, NHI – often via proportional payroll contributions/taxes
- Private insurance; medical schemes
- User fees – out of pocket
- Community financing
- Donations/grants.

Typical criteria used for assessing financing mechanisms are: feasibility, effectiveness, efficiency, equity, sustainability, structuring of contributions (which can be more progressive or regressive depending on the model used), extent of coverage, and fiscal decentralisation versus centralisation.

General tax income

General tax revenue is a source of financing for health care in many countries, particularly in countries with advanced national health service systems (the United Kingdom, Sweden, Spain and Italy). Types of taxes that underlie general tax income include personal income tax, value added tax and company tax. Taxes on alcohol and tobacco also contribute to the general revenue pool.

General taxation tends to be effective and equitable. In South Africa, the South African Revenue Service is a competent national revenue authority. Personal income tax is a particularly progressive form of raising revenue as the level of income determines the amount of the contribution, with the poorest not being taxed. It is therefore more progressive than collecting comparable resources through NHI contributions as these are based on fixed contributions according to the requirements of the NHI and not by income. Value added tax is a key source of general tax in most countries. In many countries with universal health care systems, value added tax is at a higher level than in South Africa. However no firm decision has been taken on including VAT as an additional source of funding for the NHI.

Private health insurance

Private health insurance is not an effective system for providing universal health care financing because it is voluntary, uses risk rating meaning that some people may be excluded from access or charged prohibitive fees, excludes many persons and because contributions are not linked to income.
South Africa's medical schemes are not typical private health insurance vehicles, and have already been through several sets of reforms. They are non-profit entities and risk rating is prohibited.

Medical schemes in South Africa are a well established financing mechanism used by 8.3 million beneficiaries. Government itself has three schemes for government workers – the Government Employees Medical Scheme is the second largest medical scheme in the country, with 1.4 million beneficiaries and annual contributions of R13.2 billion. Occupationally linked restricted medical schemes cover 3.1 million beneficiaries and have gross contributions of R37 billion in 2010/11. [*Council for Medical Schemes, 2010*]

Social health insurance

Private health insurance contributions are voluntary, often risk rated and not linked to income, while social insurance contributions are typically mandatory, income linked (typically as a percentage of income) and not risk rated. They are therefore more progressive than private schemes, although they typically provide a more limited set of benefits.

Payroll taxes

In some countries, NHI is funded predominantly through payroll taxes. However, once coverage becomes universal, the advantages of payroll taxes against general taxes become less significant and the more progressive nature of general taxes make them a preferable revenue-raising instrument.

User fees

Out-of-pocket payments are a regressive form of health financing and can seriously detract from access to health services. The World Health Organisation recommends that out-of-pocket payments should not constitute more than 15 to 20 percent of health financing revenue, [*World Health Organisation, 2009*] advising that the risk of catastrophic health expenditure where health costs seriously damage a households financial situation becomes minimal below these levels. In South Africa, user fees contribute about 8 percent of revenue, mainly for private services. The public sector derives only 1.8 percent of its expenditure from revenue and has exemptions for various groups.

Although user fees should not be a major component of health care financing, it is not yet clear where they should be applied. One view is that there should be no user fees at all (except for minimal exceptions such as non-South Africans, services outside the package). Another view is that user fees do have some role in controlling unnecessary demand for discretionary services, and this can be designed to avoid catastrophic health expenditure (defined as more than 10 percent of household income).

We support the broad principle of universal coverage outlined in the Green Paper on NHI and the process under way in government to investigate the most appropriate mechanisms for financing NHI to achieve universal coverage. The success of national health insurance will depend on the functioning of the public health system. The commission supports attempts to improve how the health system operates, starting with the auditing of facilities.

Measures also need to be put in place to reduce inefficiencies in the private health sector to reduce costs. This includes revisiting the Health Professions Council's decision to bar private hospitals from employing doctors. This decision has led to a private hospital model in which hospitals use incentives to attract doctors and specialists to establish practices within hospital premises. [*Matsebula T and Willie M (2007). 'Private Hospitals' in Harrison S, Bhana R and Ntuli A (eds) South African Health Review. Durban: Health Systems Trust.*] Hospitals invest in infrastructure and equipment to attract doctors and generate demand for doctors' services by referring patients, while doctors generate demand for hospital beds. This model leads to over-servicing that drives the cost of private health care.

Human resources in the health sector

There is a disparity in the distribution of health personnel, driven by differences in service conditions between the public and private sectors. This issue is linked to the funding of health. There are further difficulties in planning for human resource development, because the PERSAL system in the public sector and the health council registration system in the private sector are not providing accurate statistics. The commission proposes a number of actions to overcome the human resources challenges at different levels of the health sector.

Community-based health care

A core component of the re-engineering primary health care strategy is the proposal to place much greater emphasis on population-based health and health outcomes. This includes a new strategy for community-based services through a primary health care outreach team, based on community health workers and using advocacy on major health campaigns such as the provision of health information and responding to issues identified by communities.

Community health workers can successfully undertake a range of interventions in maternal, neonatal and child health (MNCH), as well as acute and chronic disease management. Although community health workers' activities in South Africa have been limited to a few areas, especially HIV/AIDS care and prevention, community workers are performing a wide range of tasks in a growing number of countries, especially in relation to maternal, neonatal and child health. Research has accumulated evidence of the effectiveness of community health workers in providing comprehensive health care, including treatment of common, acute, mainly childhood illnesses.

Policies permitting community-level workers to use antibiotics to treat pneumonia have been controversial, because health professionals are concerned that

antibiotics might be misused or over-used. However, in Ethiopia and Nepal, the quality of care has remained high. Supportive national policies are needed to allow community health workers to administer antibiotics for specific childhood diseases, along with strengthened regulatory and quality controls for the distribution and appropriate use of antibiotics.

Community health workers have been successful in various capacities, from approaches that emphasise community-controlled, part-time workers (Thailand, Rwanda) to those where community health workers are formal members of sub-district health teams (Iran, Brazil). In all the countries where community health worker programmes enjoy success, community participation occurs through structures that are integrated into the wider health system.

The number of tasks a community health worker can reasonably perform depends on a variety of factors, the most important being the ratio of community health workers to families, the duration and quality of their training, and the extent and quality of their supervision. [*World Health Organisation, 2010. Guthrie et al, 2010*] The Re-engineering Primary Health care policy proposes six community health workers for each primary health care outreach team, each community health worker covering 250 households, or about 1 000 people. Lessons learned from low- and middle-income countries suggest that the necessary ratios for community health workers to families should be as many as 1:500 families for full-time workers, or 1:10-20 for part-time workers. The shortage of trained staff and community workers to provide health-promoting, disease-preventing and curative services is a major hindrance to service delivery. These workers also need supervision. In the early stages of a community health worker programme, when total numbers are small, it may be most cost-effective to prioritise recruitment and allocation of community health workers to the neediest areas.

As in other countries (Brazil, Rwanda, Thailand, Bangladesh), this model should rapidly increase the poor's access to health care and result in improved health outcomes. This would be especially so if the ratio of community health workers to population increases to ensure that all households are regularly visited and health problems detected early. In several countries, high ratios are achieved through a "two-tier" system, where the ratio of full-time community health workers is 1:250-500 households, and full-time community health workers supervise part-time community health workers with more limited training.

The ratio of full-time to part-time community health workers averages 1:10 to 1:20 in countries where this system operates successfully. We propose serious consideration be given to this two-tier system. If we opt for a ratio of 1 full-time community health worker for every 20 part-time community health workers, we

will need just over 700 000 community health workers. And if we opt for the ratio of 1 full-time for every 10 part-time community health workers we will need over 1.3 million.

This cadre of community-based workers would undertake a range of health care activities, spanning the full breadth of rehabilitative/palliative care, treatment, preventive and promotive interventions. They would form the base of the health pyramid. In addition to rendering health care more accessible and equitable, this primary health care system will create more jobs and indirectly improve health by reducing the prevalence and depth of poverty.

To achieve this model of community-based health care, the power of conservative professional councils will need to be curtailed. The scope of practice for non-doctors, especially community health workers and nurses, will have to be enlarged.

Accelerate production of appropriately skilled nurses

The core of the primary health care outreach team will consist of a professional nurse, staff nurse and community health workers. This will require substantially increased numbers of trained nurses and significant strengthening of their skills to carry out and support primary health care. Because primary health care includes promotive and preventive components, the key activities of public health, these nurses (or at least the professional nurse leading the outreach team) will need to be substantially competent in public health. Indeed, in several countries, community nurses (professional nurses with public health training) lead many aspects of district health work.

Prioritising the training of more mid-wives and distributing them to appropriate levels in the health system could have an immediate positive impact on maternal, neonatal and child health, which would reduce maternal and child mortality.

The above requirements demand a rapid expansion and reorientation of nursing training. The policy decision to reopen and expand nurse training colleges is a welcome step in the right direction. However, revitalising these institutions must be accompanied by curriculum review that includes advisers external to the current nurse training bodies (Nursing Council and Sector Education and Training Authorities), with expertise in public health and experience in countries that have implemented a comprehensive, district-based approach.

Doctors and specialist support teams

According to the Re-engineering Primary Health care document, “family physicians as part of the district specialist support team in line with national policy and guidelines, should take the primary responsibility for developing a district specific strategy, implementation plan for clinical governance and provide technical support and capacity development for the implementation of clinical governance tools, systems and processes for clinical service quality in the district health system that includes the community-based services, primary health care facility services and district hospital services. Family physicians should also take overall responsibility for the monitoring and evaluation of clinical service quality for the entire district.” [*Department of Health (2011). National Health Insurance in South Africa. Policy Paper. Government Gazette No. 34523. Government Notice No. 657. 12 August 2011.]*

In many countries, the emphasis of family physician training and practice has been on individual patient care in a well-resourced context. In several countries that have promoted doctors as leaders of the district health team, these professionals have undergone training in five speciality areas (medicine, surgery including anaesthetics, obstetrics, paediatrics and psychiatry) and are also encouraged to obtain a public health qualification or training, or both. This arrangement should be considered, rather than employing orthodox specialist family physicians.

Recently, the Minister of Health announced the formation of district specialist teams. It is clear from several assessments and research studies that patient care in many district hospitals is poor. There is too little emphasis on prevention, primary health care and quality of care in district hospitals and clinics. The current output from specialist training schemes is out of step with what South Africa needs. Such training encourages continued production of system specialists, most of whom will seek and find employment in teaching institutions or the private sector (or overseas), but does not address the needs of the majority of the population, who live beyond the reach of the major city teaching centres, often in remote rural areas. Priority should also be given to developing specialists who improve the quality of care in their speciality area in district hospitals and surrounding health centres and clinics, as well as improving the planning, management and monitoring of district services in their field.

To address this challenge, there needs to be a major change in the training and distribution of specialists. It will require the accelerated production of community specialists in each of the five specialist areas. Training would include compulsory placement in regions under the supervision of provincial specialists. Those in placements would be based at a regional hospital, but would examine and improve

the standard of health care across a system or within a region – including preventive work, quality of care at primary care clinics and district hospitals, and supporting the referral and transport network.

Rapidly increase investment in health personnel development

Brazil's health system has inspired some of South Africa's key policies, particularly Re-engineering Primary Health care. Brazil has more than 2.5 million workers employed in the health sector. For direct employment in formal skilled jobs, this represents about 10 percent of the workforce – a far greater proportion than South Africa's. These numbers have been achieved by significant investment in health research and development, including expansion of training, especially for nurses and technicians, up-skilling of public health and auxiliary personnel (problem-solving and reflective thinking), and attractive incentives to promote curricular reform in undergraduate programmes.

In stark contrast, there has been stagnation in South Africa's production of doctors and, until recently, a decline in the number of nurses. Training in public health, a core component of primary health care, is minimally supported by government funding, with most schools of public health relying heavily on external donor and research funding. Most categories of health professionals – with the exception of nurses – are disproportionately located in the private sector.

To implement policies that are more appropriate to the health and health care needs of South Africa, there needs to be a massive and focused investment in training health personnel. Government could incentivise the production of appropriate trained personnel in sufficient numbers within a realistic, but short, time frame.

Review management positions and appointments and strengthen accountability mechanisms

Evidence suggests that, notwithstanding stagnation in public health personnel numbers from the late 1990s, national and provincial management has grown. The percentage growth of management posts has greatly exceeded that of posts for service delivery. Recently, reviews have been undertaken of management personnel and their competencies to strengthen and rationalise health service management. Statutory structures need to be bolstered and resourced for community representation in health system governance – it is widely acknowledged that these structures mostly function poorly. If greater accountability to communities could be secured through such mechanisms, it is likely that the quality of management and service delivery would improve.

Equip health personnel to lead intersectoral action

The Re-engineering Primary Health care policy states that: “It is well recognised that many of the factors that impact on health are outside of the health sector. Much of the work of the community-based services team is linked to improving social determinants at the community level. However there are many other factors that need intervention at other levels.” [*Department of Health, 2011*]

Intersectoral action is a feature of most successful community health worker programmes, although its implementation takes several different forms. In Iran, community health workers are the key players in intersectoral activities, while in Brazil, community health workers act primarily as health care workers and refer clients where necessary to other sectors for assistance.

The Re-engineering Primary Health care document suggests that there should be “align(ment) (of) the intersectoral programme at district level through the municipal integrated development planning process with that of the provincial and national clusters with specific time bound targets.” [*Department of Health, 2011*]

However, it is not clear who will assist community health workers and lead this work in districts and wards. This could be the role of environmental health officers, yet the current training and activities of these officers suggests that they are ill-equipped to lead such work in disadvantaged communities. This is an area for priority consideration.

Ensuring that this important aspect of re-engineering primary health care is successfully addressed requires identifying the key categories of health and health-related personnel, their respective roles, and the elaboration of appropriate and practical training programmes for them, combined with a facility for ongoing mentoring and support in the field. These actions are likely to require active enrolment of the skills of non-governmental organisations with good credentials in this type of work.

It is critical for the health sector to play an active advocacy role in other key sectors with policies that affect the social determinants of health, such as safety and security, trade, water affairs, education, and so on. Some European countries have successfully pursued integration by ensuring that the highest level of government actively promotes health-friendly policies by insisting on a “health in all policies” approach.

Strengthen human resource management

Human resources need to be strengthened at all levels by increasingly ensuring accreditation of this function, continuously reviewing remuneration and putting into operation incentive schemes such as the occupation-specific dispensation to boost services in underserved areas. Effective performance management frameworks are an important aspect of human resources management. Fulfilling these frameworks and retaining staff should receive as much attention as producing new professionals. Poor management at facility level is the most cited reason for doctors leaving the public sector, so fixing management will help address this retention problem. Recruiting skilled professionals from abroad is very difficult in South Africa, owing to considerable red tape in being granted a work permit and registering with statutory bodies. In a worldwide knowledge-based economy, South Africa is struggling to compete for this scarce resource. This matter requires urgent attention.

The full, 29-page, 527 KB PDF document is at:

http://www.npconline.co.za/MediaLib/Downloads/Home/Tabs/New/Chapter%2010%20-%20Promoting%20health.pdf

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